STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 01 B. WING	09/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	1029 EAST 5TH STREET CONNERSVILLE, IN47331

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/19/11 and 09/20/11 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Lincoln Centers for Rehabilitation and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of two separate buildings. The East building was constructed in 1977 and is a one story building of Type V (111) construction. The West building was constructed in 1971 and is a one story building of Type V	K0000	Preparation or execution of this plan of correction (POC) does not constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the Statement of Deficiencies (SOD). The POC is prepared and executed solely because it is required under law. By this response, Lincoln Centers Rehab acknowledges receipt of the SOD and alleges that it is in compliance. Accordingly, the POC is submitted as alleged compliance as of October 20, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	(111) construction. Because both buildings are the same type of construction, the facility was surveyed as one building. Both buildings are provided with complete sprinkler protection. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and single station smoke detection in the 300 Hall and 400 Hall resident rooms in the East building. The facility has a capacity of 152 and had a census of 106 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/22/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 12 hazardous areas in the West building, such as combustible storage rooms over 50 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect any residents who use the beauty shop and main dining room, which was located in the West building 600 Hall where no resident rooms are located. Findings include: Based on observation on 09/19/11 at 1:00 p.m. with the maintenance supervisor, the two 600 Hall storage rooms and the 600 Hall file storage room in the West building, located across from the maintenance supervisor's office, each measured one hundred sixty square feet in size, stored shelves of combustible paper,	K0029	K 029: It is the policy of this facility to comply with K 029 Self door closures will be installed in all storage rooms over 50ft on 600 hall All storage rooms over 50 ft on all other halls checked to ensure appropriate self door closures were in place Maintenance Director reeducated to ensure all self door closures are installed for all storage rooms over 50 ft. Maintenance Director or designee will complete a QA check all for self closing doors in storage rooms monthly x 4 weeks and then quarterly thereafter. Results of this QA review will be reviewed at the QI/QA meeting. Correction date: 10/20/11	10/20/2011

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	cardboard boxes of adult briefs, plastic mattresses, and cardboard boxes of paper, and were not provided with self closing devices on the doors. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 09/20/11 at 1:00 p.m. 3.1-19(b)			
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the sidewalk surface on 1 of 10 exit sidewalks in the West building was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice affects 22 residents who reside on the 900 Hall in the West building.	K0038	K 038: It is the policy of this facility to comply with K 038 Maintenance will repair or replace sidewalk outside of 900 hall to ensure appropriate elevation levels. Maintenance will check all entrances and exits on all halls to ensure appropriate elevation levels Maintenance Director or designee will complete a QA check all sidewalk entrances and exits once monthly x 4 weeks and then quarterly thereafter. Results of this QA review will be reviewed at the QI/QA meeting. Correction date: 10/20/11	10/20/2011

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	Findings include: Based on observation with the maintenance supervisor on 09/19/11 at 11:55 a.m., the West building 900 Hall north sidewalk discharged from the exit door onto a concrete sidewalk extending sixty four feet to the parking lot. The interconnected section of sidewalk in front of the storage garage, which measured twelve feet by ten feet had four sections of concrete broken and heaving with one inch changes in the sidewalk elevation. Based on an interview with the maintenance supervisor on 09/19/11 at 12:10 p.m., the concrete sidewalk surface in front of the storage garage broke over the past winter and began to heave. This was confirmed by the administrator at the exit conference on 09/20/11 at 1:00 p.m. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure the fuel source for	K0144	K 144: It is the policy of this facility to comply with K 144	10/20/2011

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	1 of 1 emergency generators for the West building was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off--site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:		Maintenance will contact a local propane distributor to install propane tank to ensure emergency generator fuel source is continually maintained Maintenance Director or designee will complete a QA check to ensure proper fuels are maintained once weekly. Results of this QA review will be reviewed at the QI/QA meeting. Correction date: 10/20/11	

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	1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice affects all residents in the West building. Findings include: Based on an interview with the maintenance supervisor on 09/19/11 at the 10:50 a.m. review of the Emergency Generator Weekly and Monthly Log Sheets, the fuel source for the West building emergency generator was natural gas. Based on an interview with the maintenance supervisor on 09/19/11 at 11:00 a.m., the facility does not have a letter from the natural gas provider stating that the fuel source for the generator is a reliable source. This was confirmed by the administrator at the exit conference on			

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	09/20/11 at 1:00 p.m. 3.1-19(b)			